HEALTH INSURANCE STUDIES: CONTRACT RESEARCH SERIES

Report No. 1

INTEGRATION OF INFORMATION FOR HOSPITAL RATE SETTING

VOLUME 13: THE TRANSITION TO UNIFORM ACCOUNTING AND REPORTING FOR HOSPITALS: SOME PERSPECTIVES FROM PARTICIPANTS

U.S. Department of Health, Education, and Welfare
Social Security Administration
Office of Research and Statistics
HEW Publication No. (SSA) 77-11722

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by

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This report was prepared under a contract between the Social Security Administration, HEW and the Harvard University Center for Community Health and Medical Care. The views and opinions expressed in the report are the contractor's and no endorsement by the Social Security Administration or HEW is intended or should be inferred. The project officer for this contract was William L. Damrosch, a staff member within the Division of Health Insurance Statistics, Office of Research and Statistics.

Under the HEW reorganization announced March 8, 1977 the Division of Health Insurance Studies has been transferred to the Health Care Financing Administration.

Contract Number 600-75-0142

PREFACE

The need for uniform accounting and reporting of hospital costs is recognized as an essential underpinning of efforts at cost containment. The National Health Planning and Resources Development Act of 1974, in Section 1533 (d), requires the Department of Health, Education, and Welfare to develop a uniform system for accounting and reporting costs and volumes of service provided by health services institutions. If enacted, the proposed Medicare and Medicaid Administration and Reimbursement Reform Act (Senate Bill 3205) introduced on March 25, 1976 by Senator Herman Talmadge would require HEW to establish a uniform system of accounts and cost reporting, including uniform procedures for allocation of costs and for determining operating and capital costs of hospitals providing Medicare services. Some state governments have already adopted such new systems; others are in the process of developing them.

This paper identifies some of the problems encountered by hospitals in adapting to new systems of uniform accounting and reporting. It is based on recent experience in California and Washington, where hospital commissions and hospital associations have already undergone the long and arduous task of developing new systems and where hospitals are currently learning to use them.

Until 1975, the 750 hospitals in these two states pursued accounting and reporting practices designed solely to provide their managers with the information they needed for internal accountability and control, and to meet the requirements of various reimbursing bodies. By and large, they had followed the A.H.A. Chart of Accounts. The new systems subsequently introduced by the California Health Facilities Commission and Washington Hospital Commission were designed to be compatible with these same individual management needs, but at the same time to meet the external reviewers' needs for data to permit

comparative analysis. The California and Washington Commissions therefore require that the data be defined and reported according to their standard definitions and conventions and that the information be reported to them according to standardized functional cost centers.

The transition to the new accounting and reporting systems in Washington and California has posed several important questions that are of interest beyond the particular situation of each state. How the transition was in fact prepared for; how much work and expense were involved in its implementation; what unexpected types of difficulties were encountered; and what effects the shift will have on the quality of the data reported--all these are issues that everyone concerned with the problem of prospective rate setting may soon have to face either in their own state or on a national level. While it is much too soon to find definitive answers to problems of this scope, it is certainly time to begin to define the questions that need the answers. This paper attempts to provide a first early reading from the perspective of some of the participants to signal the dangers to be avoided in future attempts to accomplish such purposes, and to suggest areas for further study and research.

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INTRODUCTION

The substantial and seemingly unending increases in hospital costs from 1965-1976 have triggered various types of cost containment efforts by the federal government and some state governments. These regulatory activities include certificate-of-need approval requirements for hospital expansion, utilization-of-services review and control through PSRO monitoring, hospital rate review and rate setting, and, eventually, local review of the appropriateness of ongoing services under the aegis of the National Health Planning and Resources Development Act of 1974. As an effort to supplement these regulatory approaches, or, in some cases, as an attempt to stave off these approaches, there has been a growing movement toward public disclosure of hospital costs.

There are three types of supporters of the disclosure movement. First, public officials and consumer representatives advocate disclosure on the grounds that hospitals are a vital and valuable public service financed largely by public funds and should therefore be accountable to the public they serve. By forcing the hospital to account publicly for its actions and expenditures, it is hoped that the hospital will develop a greater cost consciousness to avert public criticism. Second, many hospitals support the concept of reporting and disclosure of costs on the assumption that disclosure will ultimately justify to the public the "reasonableness" of hospital rates as well as document the failure of some third party payers to reimburse for the full cost of services. The third group, the rate review bodies, are generally required by statute to disclose publicly the cost data they receive from hospitals as well as their rate decisions. The rate review bodies support public disclosure both as a means of providing an incentive to hospitals to improve their cost performance and as a means of explaining many of the hospitals' legitimate cost increases to the public.

Rate review bodies are severely handicapped in their attempt to make detailed comparisons of hospital costs if the data submitted by hospitals is not uniformly reported using common definitions and organized according to functional accounting centers. Without uniformity of the definitions of units to be measured and of the categories to be employed as well as a commonality of classification and of reporting conventions, rate reviewers find themselves with the old problem of comparing apples to oranges, resulting in inequities to all parties. Moreover, without uniform data; a hospital's reputation could be severely damaged if the public review of its costs was based on inadequate or uncomparable data.

Recognizing the need for comparable data on hospital costs, the enabling legislation in California and Washington creating their respective state hospital commissions calls for the design and implementation of a uniform accounting and functional reporting system as a prerequisite for public disclosure and analysis of hospital costs. By the fall of 1975, the new systems had been developed and were being implemented in most of the 650 hospitals in California and 120 hospitals in Washington.

This study was undertaken to learn how the new systems were introduced to the hospitals in the two states and to identify some of the problems encountered by hospitals as the system was implemented. It is based on interviews with senior staff of the California and Washington Hospital Associations and Hospital Commissions who were most directly involved in the design and introduction of the new systems* and on interviews with a few hospital financial managers who had already adapted their internal accounting and reporting systems to meet the new demands. The fiscal manager of a voluntary hospital of approximately 360 beds and the vice-president of a voluntary chain of hospitals ranging in size from 50

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*Initial interviews were conducted in April 1975 by Katharine G. Bauer; additional interviews by the author in November 1975 and January 1976.

to 450 beds were interviewed in California; in Washington interviews were conducted with the controller of a 300 bed voluntary hospital and the fiscal manager of a 170 bed voluntary hospital. The hospitals in both states were located in urban areas.

The paper is organized into six sections. The first reviews the legal basis for the California and Washington systems, to acquaint the reader with the statutory authority under which uniform accounting and reporting has been mandated in these two states. The time frame for implementation of the two systems is also provided. Section II offers a brief description of the systems and discusses the effort to accommodate the external need for uniformity to the hospital's individual needs. The third section describes the organization and conduct of workshops and training sessions to introduce the hospitals to the new system. Section IV discusses the problems encountered by the hospitals as they implemented the new systems and some potential benefits resulting from the transition, while Section V focuses on specific problems with units of measure and account classification. The sixth and final section highlights the findings of the paper and offers some suggestions for future implementation efforts.

It should be noted that the primary objective of the exercise was to reveal problems to be anticipated in any such transaction from an old to a new reporting mechanism, and the observations may therefore appear unduly negative. This interpretation would be unfair. The concept of uniform accounting and reporting has been widely accepted, and the manner in which the systems have been designed and introduced appears to have earned the respect of most hospitals in both states.

SECTION I: BACKGROUND

The period from 1965-1975 has seen a marked increase in the cost of health care services, particularly hospital inpatient services, in the United States. Growing concern over these increases has led to the enactment of various cost containment measures in several states. The California and Washington Hospital Commissions were established by their respective legislatures as a means to begin to address the problem of rising hospital costs in their states. Both states include the development and implementation of a uniform accounting and reporting system as a mandated responsibility of their commissions. This section reviews the Commissions' statutory authority and time frame for design and implementation of the new systems.

The California Phased-In Approach

The California State Legislature passed the Hospital Disclosure Act in 1971, creating the California Hospital Commission and requiring all hospitals to file for public disclosure with the Commission uniform reports of their cost experience in providing services to hospital patients. The Commission was charged with developing and implementing a system of hospital accounting and uniform reporting that would enable the hospitals to fairly, accurately and efficiently prepare the required financial reports. Effective July 1, 1975, the act was amended to expand the Commission's responsibility to include all nursing homes and other types of health facilities as well as hospitals. The amended act became The Health Facilities Disclosure Act and the independent state Hospital Commission was renamed the Health Facilities Commission. However, for purposes of this paper, the earlier term, hospital commission, is used.

The Commission is given broad authority to set standards for hospital accounting and reporting to enable the public, third party payers and other interested parties to study and analyze the financial aspects

of California hospitals. Its objectives are to maintain fiscal data on the operation of hospitals; to stabilize hospital costs through public scrutiny of hospital cost factors; to enable public agencies that purchase health care services or have administrative responsibility for publicly financed health programs to make informed decisions; to have hospital cost data available for use by the Commission for comparing the performances of particular hospitals or groups of hospitals; and to perform cost effectiveness studies and research studies on the economics of health care.

Under the provisions of the act, the Commission is required to:

> ...establish approved systems of health facility accounting, uniform reporting, and auditing to create, to the extent feasible, one uniform comprehensive state system which takes into account the data requirements of all state programs.*

In accord with this charge, the California Uniform Accounting and Reporting Manual was developed by Ernst and Ernst, Inc., for the Commission in close cooperation with the California Hospital Association, the United Hospital Association, and the local and regional hospital councils. Rules and regulations prescribing the uniform system were adopted on March 17, 1973.

The designers of the California accounting system attempted to develop procedures that would be compatible with the organizational structure of a majority of the hospitals and that would give the hospitals flexibility to accommodate their internal needs while meeting the broader public needs of uniformity and comparability of data. It should be noted that the California system was not designed for existing cost reimbursement or immediate rate setting purposes, but could be used for rate setting on an equal payment for equal service basis.

Implementation of uniform accounting and budgeting was planned on a phased basis. As the first phase, in July 1974, the uniform chart of

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* California Health and Safety Code, § 441.16

accounts was implemented for approximately one third of the California hospitals that have fiscal years ending on June 30th. For these hospitals, the first year-end reports according to the uniform reporting system were submitted in October 1975, four months after the close of the June 30th, 1975 fiscal year. Other hospitals were phased into the system according to the month in which their fiscal year ends and are now required to submit the year-end reports to the Commission upon completing each fiscal year on or after June 30, 1975. For some hospitals, the first reports are not due until October 1976.

Following the Commission's implementation of the uniform accounting system, the California Hospital Association developed a recommended uniform budgeting manual to lay the groundwork for future rate setting. This standard budget manual is not mandatory, but it is hoped that it will be used by hospitals without budgeting systems to introduce budgeting. It was noted that the budget manual is too elementary to meet the full budgeting needs of the larger and more complex hospitals.

Eventually, but at no specific time, a prospective rate review program is planned. However, both the California hospitals and the Hospital Association stress that rate setting will only be instituted after the hospitals have learned to cope with the reporting and accounting system, a data base has been established, and all hospital third party payers have agreed to pay their "fair share" of costs or charges. In establishing a data base, it was noted that during the first year or two of the new reporting system, there was bound to be a great deal of inaccurate and incomplete data submitted. Although no target implementation date for prospective rate setting has yet been determined, the Commission's November 1, 1975 report expressed the view that public disclosure of costs was not sufficient and must be accompanied by budget, rate and capital expenditure control. Since California's disclosure law was passed in 1971, prior to the Economic Stabilization Program, the legislature took the posture that uniform accounting and disclosure was enough for the time

being. According to some respondents, this attitude still prevails making it difficult to amend the law to implement ratesetting.

Washington's Combination Approach

The Washington Hospital Commission was established by the legislature under provisions of Chapter 5, Laws of 1973, and approved by the Governor on March 23, 1973. Enacted in the midst of the Economic Stabilization Program, the primary purpose of the Act is to promote the economic delivery of high quality and effective hospital health care services by establishing a hospital commission with authority over financial disclosure and budget and prospective rate review. The commission is to assure all purchasers that total hospital costs are reasonably related to total services, that hospital rates are reasonably related to aggregate costs, and that such rates are set equitably among all purchasers of these services without discrimination. The legislature declared that:

> ...health care is a right of the people and one of the primary purposes for which governments are established, and it is, therefore, essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiralling costs.*

In addition to these global responsibilities, the legislation states that the commission shall establish by the promulgation of rules and regulations "a uniform system of accounting and financial reporting, including such cost allocation methods as it may prescribe by which hospitals shall record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service." The statute also requires all hospitals to file with the commission an annual report which includes a balance sheet detailing the assets, liabilities, and net worth of the hospital; a statement of income and expenses; and "such other reports of the costs incurred in rendering services as the commission may prescribe." Additionally, the commission was required to begin reviews of the hospitals' costs within two years of adopting the uniform system of accounting and

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* Washington Public Health and Safety Code, Chapter 70.39.010.

financial reporting.

Borrowing heavily on the work of the California Hospital Commission and the California Hospital Association, and with the assistance of Arthur Anderson, Inc., the Washington Hospital Commission developed a uniform chart of accounts and a reporting system that was adopted in formal hearings on September 30, 1974, and became effective October 1, 1974. For fiscal years beginning on or after October 1, 1975, the Washington hospitals were required to submit prospective budgets for review and approval by the Hospital Commission. These budgets were to be based on the Commission's chart of accounts and functional reporting requirements. Thus, six months after adopting the new accounting system, the hospitals in Washington were asked to use their new chart of accounts to prepare a budget for rate setting by the Hospital Commission.

SECTION II: ACCOUNTING FOR DIVERSITY

The 650 hospitals in California and 120 hospitals in Washington differ substantially in terms of size, scope and range of services, location, type and number of staff, type of cases treated, etc. The designers of the California and Washington uniform systems sought to address these differences by building flexibility into the accounting and reporting systems through the numbering system for the chart of accounts and/or by adopting special provisions for small hospitals. These methods are reviewed below after a brief description of the uniform accounting manual used in California and Washington.

The Uniform Accounting Manual

The uniform accounting manuals in California and Washington set forth the system's basic accounting principles, the chart of accounts and numbering system to be used, and a system of functional reporting to provide cost figures according to type of activity to permit comparability among hospitals for analysis of revenue and expenses. The Washington manual is based on the California manual because in lieu of designing a totally new and different system, the Washington Commission chose to modify the California system to conform specifically to the needs of the Washington Commission and hospitals. Therefore, since the manual implemented by the Washington Commission closely resembles the California manual in both structure and content, a separate section by section description of that manual will not be provided.

The California uniform accounting and reporting manual is divided into seven sections: Section 1000, Accounting Principles and Concepts; Section 2000, System of Accounts; Section 3000, Account Distribution Index; Section 4000, Statistics; Section 5000, Cost Finding; Section 6000,

Interpretations; and Section 7000, Reporting Requirements. Section 1000 sets forth the basic accounting principles that are followed throughout the manual.

In Section 2000 on the System of Accounts, the chart of accounts is outlined with a description of the nature and content of each account. The chart of accounts is a listing of the account titles with numerical symbols to be used in the compilation of financial data concerning the assets, liabilities, capital, revenues and expenses of the hospital.

The account distribution index in Section 3000 is a reference guide to assist in the proper classification of supplies and service expenses. This index lists various types of supplies and services and the cost center to which they should be charged as expenses. In some cases the cost center which originally receives the supply items is not the cost center to which the supply expense is charged.

The statistics section, Section 4000, presents a definition of the terms used in the manual and defines the standard units of measure to be used in measuring the costs and volume of service in the hospital's revenue and non-revenue-producing centers. For example, the statistics section states whether occupational therapy services are to be measured by number of treatments, patients, or some other measure, and defines the method of measurement.

The cost finding section sets forth the principles governing the development of the required sequence of allocations for identifying costs with the production of revenue. The cost-finding process allocates the cost of the non-revenue-producing centers to each other and to the revenue-producing centers on the basis of statistical data that measure the amount of service by each center to other centers. The purpose of cost finding is to determine the total or full costs of operating the revenue-producing centers of the hospitals. Reclassifications are recognized as necessary to adjust the hospital's records to the reporting requirements of the Commission if the hospital has combined some of the Commission's departments

or recorded the expense associated with a particular function in a cost center that is different from the functional description in the manual.

The 6000 Section entitled Interpretations contains the rulings, interpretations, and revisions made by the Commission after the manual was issued. For example, the Commission modified the requirements for hospitals using inclusive rates in which the patient's charge is independent of his use of particular services.

The manual's final section, Section 7000, reviews the reporting forms to be submitted to the Commission by the hospital four months after the close of its fiscal year. A complete sample set of forms and instructions is provided. The actual forms for submission are provided to the hospital at the time they are required to report.

The Numbering System for the Chart of Accounts

Both the California and Washington uniform accounting manuals specify a numbering system to be used with the chart of accounts. The manual assigns a revenue and an expense number to each cost center. In both states there is a 3000 differential between account numbers for the same cost center to permit the matching of revenues and expenses. For example, the account number for medical-surgical revenue is 3010 and the account number for medical-surgical expenses is 6010.

In the manuals' six-digit numbering systems, the first four digits of each account describe the account and the last two digits provide a secondary breakdown indicating the kinds of expenses and revenues. The secondary breakdown allows the hospital the flexibility necessary to retain their responsibility accounting system while complying with their Commission's functional accounting requirements. The hospital personnel can continue to think of all departments as they have in the past, but the numbering system allows the computer to accumulate all revenue and statistics in departments as defined by the new chart of accounts.

For example, although anesthesiology is not organized as a separate department in most hospitals, the California Hospital Commission manual requires that anesthesiology be reported as a separate account. By using the last two digits to identify revenue and statistics in other departments that are attributable to anesthesiology, the computer can be programmed to pick up the appropriate anesthesiology codes wherever the services are provided in the hospital and accumulate those statistics and revenue figures under account number 4040, anesthesiology. Thus, at the department level responsibility accounting is maintained and by using the numbering system's coded breakdowns, functional accounting can also be achieved.

The hospital can employ the same procedure for blood, medication, central supply items, and other services or items aggregated by function in the manual and by responsibility for the hospital's internal purposes. All of these items are assigned to the appropriate functional account by the computer no matter what particular hospital department issued or used them. As will be pointed out in the discussion of central services in the section that follows on units of measure and problem accounts, the hospital financial officers in both California and Washington view the flexibility built into the numbering system as essential in allowing them to adapt the Commission's accounts to meet their hospital's individual reporting needs.

The manuals also contain a provision for departments that may exist in the hospital, but are not defined or recognized in the manual. In the California manual, these departments fall into department number 441X which is referred to as "other ancillary departments." If more than one undefined department exists, a hospital uses the fourth digit (the "X") to differenciate. For example, a hospital might assign the Gastro-Intestinal Laboratory the account number 4411 and the Heart Catherization Laboratory the account number 4412. This mechanism allows the hospital to expand the chart of accounts to meet its own specific needs. This provision is especially important for large hospitals that

require a detailed breakdown of multiple accounts for internal review purposes.

For the smaller hospitals, the numbering system gives direction for their own internal accounting systems. With less complexity in their internal accounting system and fewer undefined or ancillary departments, the smaller hospitals will not have to expand the codings to the same extent as the larger hospitals. This flexibility in the numbering system allows the smaller hospital in some cases to simplify the level of reporting to produce internal reports tailored to their own needs while still producing uniform reports for the Commission.

Accommodating to the Small Hospital's Needs

There are, however, some characteristics of small hospitals, such as the lower level of departmentalization as compared to large hospitals, that make conformance with uniform accounting system requirements difficult. Since the small hospital has fewer departments than a large hospital or the Commission manual requires, it does not break down its statistics at the level of detail required by the Commission. This creates problems in terms of the hospital's ability to separate out revenues and expenses according to the presented categories. A small hospital might have to estimate the distribution of the time and salary costs of a person who performs a variety of functions between the different cost centers specified in the manual. If the manual's level of detail is greater than the small hospital's actual breakdown of services, the small hospital must estimate the breakdown instead of reporting actual statistics. As one respondent pointed out, by forcing the small hospital to estimate, the system's objective of uniform accounting and reporting for all hospitals could be jeopardized. Illustrations of this problem are provided in Section V.

While small hospitals in California encounter these types of problems,

the California Hospital Commission has not attempted to develop options within the system to accomodate their special needs. Some observers think that the Commission will adopt modifications for small hospitals after the Commission staff reviewed the quality of the data from small hospitals on the first set of year-end reports. Others say that because the data is to be used only for public disclosure and not for rate setting, the small hospitals and others are not alarmed at the prospect of receiving estimated or inaccurate data from the small hospitals. One observer believes that when rate setting occurs, the small hospitals will make their difficulties widely known and, as a result, some options will be developed by the Commission.

On the other hand, Washington, with budgeting and rate setting in place, waived some of the requirements for the first year and developed some options within its system to adjust for the differences between small and large hospitals. After hospital protests and consultations with the Washington Hospital Association, the Commission became convinced that the many small hospitals would not be able to supply the level of detail requested and that rate determination for small hospitals did not require the detailed reporting necessary for the more sophisticated hospitals. As a result, the 47 Washington hospitals classified as basic service hospitals were permitted to use a simplified budgeting system that allows some cost center accounts, specifically designated by the Commission to be aggregated. The classification system is based on a series of factors found to be statistically significant in describing the similarities and differences among hospitals; bed size is only one such factor.

For example, the Washington reporting forms specify seven cost centers in the Administration and General Services category--administration, public relations, management, engineering, personnel, auxiliary groups and the chaplaincy. In many small hospitals this entire range of functions may be performed by one or two persons. To accomodate to this kind of reality and to prevent arbitrary estimation, the Commission

has collapsed the seven cost centers into one for basic service hospitals. Similarly, the fifteen fiscal services cost centers which include patient accounts, admitting, billing and communication were collapsed into two cost centers. The Commission's Interpretive Bulletins mailed periodically to the hospitals specify these types of combinations and inform the small hospitals of their options in completing the budget package.

One might ask if the Commission's options for basic service hospitals have not destroyed the Commission's ability to perform comparative analyses. The Commission points out that it would be a fruitless exercise to compare the administrative costs of a 35 bed hospital to those of a 350 bed hospital. Under the Washington hospital classification system, hospitals are grouped and then compared with hospitals of a similar level of complexity. Therefore, in the budget review process, the basic service hospitals are compared with other basic service hospitals using the same aggregated summary accounts while the large hospitals are compared with other hospitals reporting in fuller detail.

In Washington, then, the issue becomes not whether the reporting system is impossible for smaller hospitals to meet, but what is classified as a basic service hospital. There is a very find line between the ability of a hospital with 60 beds to meet detailed reporting requirements and that of a hospital with 70 beds. As with the Medicare system, drawing the line between "small" and "large" hospitals is really an arbitrary decision that inevitably creates special problems for the borderline hospital.

SECTION III: INTRODUCING THE HOSPITALS TO THE SYSTEM

The successful implementation of a uniform accounting and reporting system appears to require both extensive training and a coordinated schedule for implementation. The nature of the sessions to instruct hospitals in Washington and California on the implementation of their new accounting systems is described below. As the discussion reveals, the California and Washington Commissions followed similar approaches.

The California Format

The hospital financial officers interviewed in California were pleased with the quality and level of assistance that they received prior to implementation of the new accounting and reporting system. The California Hospital Association (CHA) held a series of workshops in addition to those conducted by the California Hospital Commission. For both sessions the director of finance, controller and in many cases the assistant controller of the hospital attended. There was also a separate session just dealing with the forms that was attended by the accountant and in some cases the controller, but usually not the director of finance. One of the interviewees felt that the Commission's accounting system had been accepted by the hospitals primarily because of these training sessions and noted that the discrepancies between the way one hospital adopted the A.H.A. chart of accounts and another was probably due in part to the lack of any kind of real training by the A.H.A. on how to implement the A.H.A. chart of accounts.

The sessions were conducted on a regional basis with approximately 40 people in attendance, although attendance levels varied from region to region. The CHA also held a separate seminar for the hospital directors of finance to help alleviate their fears about the potential outcome of the uniform accounting and reporting system--i.e., its implications for rate setting.

The faculty for the regional workshops consisted of two accountants from Ernst and Ernst and a financial analyst from the California Hospital Commission. It is reported that they did a fine job and the reception among the hospitals was generally positive. One respondent commented that the general training was of a high caliber, but was still problematic for some of the smaller hospitals due to their lack of accounting sophistication.

The hospital financial officers interviewed felt that one of the greatest benefits of the workshops came not from the training itself, but from the opportunity to meet with and discuss the implementation of the system with other hospital administrators. They suggested that the CHA most likely helped to sponsor these sessions with that purpose in mind. In addition, the respondents emphasized that they hoped the California Hospital Association and the Commission would continue to sponsor such sessions to update and continually educate individuals on how the accounting system could be used. They felt that the one series prior to implementation was sufficient for that time in the hospital's experience, but additional workshops are needed when the hospitals begin to actively implement the system.

Following the one day workshop for hospitals on a regional basis, there was a second series of half-day workshops six months later to answer questions that had arisen in the interim period. There was also a demonstration project in which a group of hospitals tried to use the new accounting system. Approximately six to eight hospitals began the system and four to five hospitals actually completed the demonstration project. This project was conducted by Ernst and Ernst and was used as a method of identifying the problems on a test run before they were implemented on a state-wide basis.

One of the hospital managers interviewed felt these sessions had assisted him in developing useful tools that could be used for individual training sessions within his own hospital. However, as a recommendation

for future efforts, he urged that top administrators and board members be required or, at least, encouraged to attend. He felt that this would help top management to realize the impact of the new system on their hospital as well as serve as a means of educating the board and administrators to the need of allocating more staff resources to the accounting department to assist in the implementation of the new system.

The Washington Format

To acquaint the hospitals with the uniform accounting and reporting system, a three-pronged effort between the Washington Hospital Commission, the Hospital Association, and the Washington State Chapter of the Hospital Financial Management Association (HFMA) was undertaken. In this effort, 5 workshops were conducted throughout the state. The first group of hospitals scheduled for review by the Hospital Commission was invited to attend the first workshop to enable these hospitals to have the benefit of the workshop in advance of having to complete the forms. Thus, hospitals were assigned to the workshop not by geographical location but on the basis of their fiscal year. Each hospital was invited to attend a workshop which took place approximately 5 to 6 months before their fiscal year ended.

After the initial five invitational workshops were conducted, two more were scheduled and open to any hospital that wished to attend. These additional workshops were scheduled due to the increased interest among the hospitals. In other words, many hospitals after attending the first session, requested permission to send a representative to another session to learn more about the budget package. Only two hospitals in the State of Washington did not attend any of the workshops, and many hospitals sent representatives to more than one session. Both the administrative and fiscal staff of the small and medium size hospitals generally attended, but the large hospitals usually sent just their fiscal staff.

Recognizing that many of the CPA firms in the area would be ultimately responsible for completing many of the hospitals' budgeting forms, the Commission and the Hospital Association undertook to obtain continuing education credits for CPA firm representatives who attended the sessions. The Hospital Association and the Hospital Commission feel that encouraging CPA attendance at the sessions was a very important factor in the successful implementation of the system. They recommend that in any future attempts to implement uniform accounting and reporting both the hospitals and the accounting firms which serve them be introduced to the system at intensive workshops.

The workshops were scheduled for two full-day meetings in each of the initial sessions. In light of feedback from the first workshop, more time was devoted to the direct expense forms and less time to the cash budget forms, to reflect the hospitals concerns. A representative of the state hospital association observed that the direct expense forms were the most cumbersome to go through because they involve a complex flow of dollars within the hospital.

It was suggested that the hospitals could have made the process much easier if their personnel had studied the Commission forms prior to attending the workshops. Most hospitals, it seems, did not review the forms before coming and then had a difficult time following what was going on in the sessions. It was recommended that any future training attempt try to emphasize the need for the hospitals' staff to spend a significant amount of time reviewing the forms before attending the workshops.

The three person faculty panel for the workshops consisted of the deputy director of the Hospital Commission, one CPA firm representative and a controller selected from one of the Washington hospitals. The same individuals did not serve as faculty for all five sessions. However, the deputy director of the Washington Hospital Commission served on all workshop panels as a resource person on the Commission's requirements.

The Washington Hospital Association strongly supported the effort to present the materials in workshops. All faculty for the sessions were supplied on a voluntary basis by their accounting firms or by the Hospital Association.

At the early workshops, many of the hospitals wanted to raise questions about how the Commission was going to use the information from the uniform reporting system and on the Commission's philosophy on rate reviews. Due to the complexity of the technical material, the workshop moved quickly in the sessions to cut off such questions and require the hospitals to deal just with straight issues of how to complete the budget package. It was recommended that any similar activities in the future clearly specify in the announcement of the workshop that the purpose is not to discuss rate setting itself, but an intense training session on how to use the new forms.

Prior to each workshop, the hospitals received a draft of the manual. One criticism of the workshops was that this manual was in very rough form with poor quality photocopying, making it very difficult to read. In addition, the copy was not paginated so it was very difficult to find the pages referred to by the workshop staff. The written instructions were not always complete; some of the xeroxed sheets were very light, and others were almost totally unreadable. The individual raising these objections said that he recognized that the materials had been quickly distributed very near to the target date, but wished that some method had been found to allow more lead time to review the forms before attending the sessions and to provide a more readable set of forms to work with.

However, this same individual expressed his appreciation of the Commission's attempt to solicit the hospitals' reactions by distributing a draft copy of the forms instead of a finalized version. By working with the draft copy, the Commission was able to obtain the hospitals' comments at the workshops and incorporate them into the final version.

In other words, it seemed to be a matter of trade-off--the forms were more difficult to work with because they were still in draft, but because they were still in draft the hospitals had a chance to have a real impact on the final design. In fact, based on feedback from these workshops, the Commission and its Technical Advisory Committee made a number of revisions in the chart of accounts.

The fiscal manager interviewed at another hospital felt that the training sessions were inadequate and confusing because they attempted to present too much detail. He felt that there was not enough time to digest the material presented or to obtain the detail necessary to complete the forms. In the future, he recommended, implementation should be paced to enable the hospitals to master one step before they move on to the next and to allow enough lead time to produce readable manuals. He also urged simplification of the reporting package, which would help alleviate the training burden. Moreover, he urged that future training sessions be smaller to help promote discussion.

In retrospect, the Washington Hospital Commission suggests that the introductory program could have been improved with even more intensive training and with more catch-up sessions to accomodate staff turnover in the hospitals. They had two open sessions at the end for hospitals that either missed their scheduled session or wanted to send either additional or new personnel. They are now considering conducting periodic training and review sessions to enable new hospital staff to take advantage of the sessions that veteran staff have already attended and to provide in-depth training on problem areas and special issues. Workshops geared toward developing more reliable statistics for measuring units of service was viewed as a much needed activity. The decision to encourage CPA attendance at the sessions was viewed as an important step in making the transition to the new accounting and reporting system smooth and orderly.

SECTION IV: COPING WITH IMPLEMENTATION

In order to implement the California or Washington uniform accounting and reporting system, the hospital managers had to adopt a new chart of accounts and alter some of their familiar practices and ways of reporting their hospital's revenue, expenses, and performance statistics. Many variables such as the timing for implementation, problems with computer services, and arrangements with CPA firms can affect the smoothness of the transition. Furthermore, as with any type of system change, there are administrative burdens and implementation costs. This section reviews some of the problems encountered by hospitals as the new systems were implemented, and some of the system's potential benefits.

Timing

The timing for the implementation and use of the uniform accounting and reporting system for rate-setting purposes differs significantly between California and Washington. As discussed in the background section, the California Commission has chosen to follow a phased-in process, while the Washington Commission implemented its uniform accounting system and six months later required hospitals to use that system to submit budgets for rate determination by the Commission.

The general consensus among hospitals and hospital association members in Washington was that the Commission had moved too fast in implementing the uniform accounting system, the reporting system and the budgeting system. It was generally felt that the first year's budgeting would have been much more successful and efficient if the hospitals had had more time to familiarize themselves with the new accounting system before the budget reviews began. A minimum lead time of 18 months for the hospitals to adapt to a new system and to use it for budgeting and reporting was suggested. However the Commission did waive the requirement that

the hospital submit the statistics and financial data for the prior year on the first year's budget forms. Only data for the current year and budget year were required.

Some observers believe the Washington Commission has been particularly lenient in the budget reviews during the first review year because they recognize that the system is very new and the hospitals may need time to adapt, but others feel the timing problems have not been given enough recognition. One individual whose hospital's budget request was cut by the Commission in the review process complained that it was an unfair action since the budget was based on the new chart of accounts and the decision was made on the basis of 18 months estimated data and only 6 months actual data. This individual had no objection to requiring the hospitals to report to the Hospital Commission during the first year, but felt that using the data for budgeting was "too risky a proposition."

Because California has followed a phased-in approach to implementation, the California counterparts of the Washington hospitals' financial managers do not share the same complaints about the short time between the introduction and implementation of the system. However, the California phasing-in process and the fact that the eventual rate-setting process and payment method have not yet been specified mean that the types of data and level of detail in the reporting system have been designed without the benefit of knowing the purpose for which the data will be used. While this is obviously a disadvantage that could result in requests for data items that are inappropriate or will not be used, some argue that it permits the Commission to collect unbiased data from the hospitals for establishment of a data base. They argue that the hospital financial officers prefer not to play accounting games because if the hospital has miscalculated on the accounting rules when the prospective system is designed, the hospital could be trapped by its own reports. Advocates of this line of reasoning urge hospitals to be honest and

reveal their true costs in relation to the services they provide. If this philosophy is followed by the hospitals, the data base for prospective rate setting will be reliable and useful. However, if the hospitals object to spending time and energy filling out reports that, as far as they can see, will not be used, it is likely that the data submitted will be incomplete and inaccurate--and thus unreliable as a data base.

Administrative Burdens and Implementation Costs

All participants interviewed agreed that there are administrative burdens and implementation costs imposed on a hospital that has to switch to a new uniform accounting and reporting system, but differed in their perceptions of the degree of the imposition. Both the Commissions stressed that the gross costs of conversion could not be separated from the expected benefits of such a conversion. The Washington Commission believes that present redundancy of hospital reporting will be greatly reduced when the system is in place and that the improved accuracy of the reporting will reduce the hospital's potential for loss under the lesser of costs or charges provisions of federal reimbursement programs. Moreover, the Commission stresses that implementation is a one time expenditure that will probably result in long range savings. Namely, the more sophisticated information and budgeting could reveal out-of-line staffing patterns and help to effect management improvements.

The Washington Hospital Commission's early estimates for startup and conversion to the new system ranged from $10,000 to $50,000 in direct one-time implementation costs per hospital. For a 100 bed hospital, the initial cost was originally estimated at a maximum of approximately 50 cents per patient day per year. Based on the first year experience, the Commission now feels that implementation cost is probably only about $5,000 per hospital. Even if the hospital initially hires a new person to help implement the system, by the third or fourth month that person is likely to be doing other things unrelated to the Commission's requirements and therefore, his salary should not continue to be considered a Commission imposed burden.

A fiscal manager for one of California's hospitals reported that the hospital hired a new accounting analyst to implement the system. This person's main responsibility was to see that each department was correctly collecting the statistics required for the functional accounting system and that data for expenses and revenues were collected according to the manual requirements. After approximately one month, the system was put into place and this person was no longer required on a full-time basis for commission-related functions. He was then assigned to perform other internal management tasks. However, in Washington, one of the hospital managers stated that his hospital had to hire an additional full time person with an accounting background just to handle the Commission's accounting and budgeting requirements.

The fiscal manager interviewed at the 170 bed hospital in Washington estimated that a solid three weeks were spent completing the budget package. He estimated the task required 200 hours of his time and 80 hours of a clerk's time. It was anticipated that the time required could be trimmed by 10 hours next year since the forms will be familiar. Another small acute care hospital reported to the Commission that the budget had been prepared in 180 hours and hoped to trim the figure next year. The controller of the 290 bed Washington hospital said that it took him and his staff "thousands of hours" to fill out the forms that they had to submit to the Commission. He said that the hours spent were not for retroactive collection and review of data, but for identification and comprehension of the requirements and reworking of the data already supplied by his computer into the proper format for inclusion in the forms. He spent several weeks reviewing the forms to determine what was required. He then worked with the departments to tell them exactly what data was needed and with computer services to begin to get quick and dirty runs to show each department their cost picture. This early planning insured that the necessary data for completion of Commission reports was collected throughout the year.

The Washington Hospital Association reported that one small

hospital used 200 hours of consulting time, and another one 250 hours to complete the budget package. Although the conversion cost is an allowable expense and can be included in reimbursement claims to third party payers, one Washington hospital paid a CPA firm $6,450 to prepare the budget package while the hospital's own net income was only $14,000 for the year. The figure of $6,000 just to prepare the cost reports of one small hospital was said to be not atypical of other small hospitals, but did not begin to account for the costs in a larger facility of redoing the computer programming.

In addition to the implementation costs in terms of both dollars and staff resources, one fiscal manager pointed out that for him the change in account numbers was difficult to adjust to on a personal level. He said that the account numbers from the old A.H.A. chart of accounts were just ingrained into him and he was having a great deal of difficulty learning all the new numbers and remembering to use them. He felt that the new numbering system would create errors because one would tend to remember the old numbers and use them instead of the new.

While the acceptance of the uniform accounting and reporting system naturally varies from hospital to hospital in the two states, the general consensus among the hospital association representatives interviewed seems to be that the demands of the system are not really unwieldy for any of the hospitals. It was felt that after the initial implementation problems were resolved and the system achieved full operation, hospital administration will begin to recognize the capability of the system to provide useful and additional information for hospital management. There was also some indication that in both California and Washington the cost and burden of implementation of the new system would be generally accepted if the hospitals perceived that this system would end their multiple reporting requirements. Unfortunately, at the present time this is not the case in either state. Both in Washington and California, Medicare and Medicaid as well as other reporting agencies and third party payers require their own reporting forms often using different statistics and formatting. One hopes that this situation will soon be

alleviated and one uniform set of definitions and reporting requirements will be used by all third party payers.

Computer Problems

As discussed in Section II, implementation of uniform accounting and reporting can be accomplished in a hospital without major disruption to the responsibility reporting system if the computer system is modified to provide for the accumulation of revenues and expenses according to either functional or responsibility accounts. While cognizant of the benefits of computerization, several of the hospital association representatives and hospital financial managers indicated that computer services consituted one of the major obstacles to successful implementation of the new systems.

In a few of Washington's hospitals with computerized record systems, severe problems were encountered when the computer companies under contract to the hospital either went out of business or merged with other companies. These hospitals were left to cope with renegotiating computer contracts in the midst of trying to redesign their own accounting systems. One fiscal manager interviewed said that his hospital had two different computer companies and four computer company representatives during the twelve month implementation period. If there had been more lead time between development and implementation of the system and the rate reviews, the crisis situation of not having computer contracts for two or three months would not have been as severe. The computer conversion problems prompted several interviewees to observe that the smaller hospitals were often in a better position to accept the new accounting system because they did not have to negotiate with or pay outside computer service companies to reprogram the accounts. Those hospitals which were semi-automated (partially computerized) often had the most problems due to the difficulty in accomodating their simplified computer system to a more detailed set of accounts and reporting requirement

categories.

The fiscal manager of one of the large Washington hospitals stated that the Commission's new chart of accounts system had not yet been implemented in his hospital because transformation required such extensive computer reprogramming. Their computer system is highly sophisticated with all of the account numbers separately keyed to the American Hospital Association (A.H.A.) five-digit chart of accounts and with all payroll codes matched to the A.H.A. codes. Therefore, instead of internally switching the accounting numbers, the old account numbers were retained, and at the end of the year the computer was used to reclassify the information to conform with the Commission accounts. Since the hospital's old accounts followed those of the Commission except for the numbering system the account numbers of the cost centers could be easily transformed by the computer. Items such as employee fringe benefits and central supply revenues and expenses were handled by reclassification.

However, because of the time-consuming nature of the reclassification process, it was anticipated that in the coming year, the hospital would reorganize its internal system to use the Commission's account numbering system. It was suspected that the conversion would prove to be time consuming and costly, although--admittedly--a one-time expense. In this regard, the smaller hospitals may really be at a big advantage because they can handle most of the necessary transformations in account numbers manually. As a result, it might be necessary to allow a large hospital with a complicated computer system more lead time than is needed for small hospitals or was allowed by the Washington Commission.

Agreements with CPA Firms

Another issue of concern to the hospital is the availability and cost of CPA firms to assist in the completion of the reporting and budget packages. One hospital association representative interviewed stated that the CPA firms bill hospitals at a rate of $30 per hour to work

on projects such as the budget package. At that hourly rate he maintained that it is imperative that the reporting requirements for a hospital not be so extreme that it will cost them disproportionate amounts of additional dollars just to prepare the forms. While the CPA rate would be the same for large or small hospitals, the burden of the cost of purchasing CPA services to complete the reporting or budgeting package often falls heaviest on the small hospitals because they often lack the personnel or accounting sophistication to complete the package on their own. By simplifying the reporting requirements for the small hospitals in Washington the CPA cost burden on these hospitals was probably reduced.

Many small hospitals utilizing the services of local Certified Public Accountant (CPA) firms in Washington encountered problems in obtaining their services. In some cases, the local CPA firms viewed the Washington Commission's report forms as so complex and time consuming that the hospital was told to seek another accounting firm to do their reports for them. In several cases reported, the accounting firm pulled out and left the hospital to fend for itself in completing the reporting package. In addition, some concern was expressed that because of the rapid implementation schedule, some of the local CPA firms may not be acquainted with the detailed requirements of the budget package and may be unable to do an adequate job when completing the hospital forms. Consideration has been given to conducting an in-depth training session solely for CPA firms, but such a session has not yet been held. However, it should be recalled that the CPA firms were invited to attend and in many cases did attend the training workshops sponsored by the Washington Commission, the Hospital Association, and the Hospital Financial Management Association.

However, among the small hospitals on the eastern side of Washington, a different type of CPA problem arose due to fiscal year scheduling. Several small hospitals had contracted with a local CPA firm for completion of their budgeting package as well as for other auditing services. Since

five of these hospitals were on the same fiscal year, their budget packages were due at the same time. As a result, at least two hospitals submitted late packages because the CPA firm was unable to handle the workload involved in preparing budget packages for several hospitals, especially given that this was the first year that the package was required.

The difficulties encountered by the small hospitals in eastern Washington raise an issue that must be addressed for both small and large hospitals. Namely, should all hospitals be required to use the same fiscal year for accounting and reporting purposes? Those who advocate use of the same fiscal year for all hospitals say that hospital grouping and comparisons are difficult and possibly unreliable if the data reported is for different time frames. Those who advocate allowing the hospital the autonomy to select or retain its own fiscal year point out the tremendous overload from a single reporting time on accounting firms and the Commission itself weighs heavily against a uniform fiscal year. The experience in eastern Washington adds credence to that view.

Burdens on Small Hospitals

Both the designers and users of the accounting and reporting systems in Washington and California readily admit that many of the detailed reporting requirements as well as some of the general transitional adjustments and problems could, and probably do, impose a severe burden on the small hospitals. In California, the small hospitals are required to use the same statistics, cost centers, breakdowns, and reporting format as the large hospitals, but in Washington special provisions have been made to accomodate the small hospitals.

In California, some concern was expressed over the small hospital's ability to introduce and accomodate to the new accounting system, particularly if the hospital was not computerized and had a staff of only one or two accountants. The financial officer of one of the large hospitals interviewed indicated that heavy reliance was placed on the hospital's

computer capability and a team of four or five accountants to implement the new system. It was believed that a limited accountant staff might be hard pressed to perform the hospital's routine tasks in addition to phasing in the new system. Other observers expressed the opinion that a number of the small hospitals in California do not have staff with the special sophistication and training to adapt to such a complex system. If this is indeed the case, special training sessions should be conducted for the small hospitals or outside consultants hired to assist them in completing the reporting packages.

In some regards it was felt that the small hospitals might be in a more advantageous position than the large hospitals. One interviewee cited the types of computer problems described in the preceding section as an example. Computer problems could throw the whole system in a large hospital in total disarray, but the small hospital with its manual system would be able to adapt without complex negotiations with a computer company to reprogram much of the hospital's data. It was also pointed out that a computer can only generate data; it cannot fill out the Commission's forms. In terms of filling out the forms manually, the large hospitals have the same problems as the small hospitals, but they do have a larger staff to cope with the new task.

The fiscal manager of a large Washington hospital felt the small hospital manager was in a better position to implement the new accounting and reporting system than the manager of a large institution. In a small hospital the manager has control over the entire "operation" and can discuss the data collection system individually with each of his department heads. The manager of a large institution often has little contact with the department heads and thus may be unable to gain the cooperation and assistance of the departments. In this manager's view, bigger is not always better.

Potential Benefits to the Hospital

Although uniform accounting and reporting does cause some disruptions in the hospital during the implementation phase, many of the hospital financial officers and association staff interviewed cited advantages to hospital management from its implementation. They say the new system can serve to strengthen hospital internal management processes by providing a broader scope of information on hospital operations than has been available in the past. Hospitals can now compare themselves with other hospitals to determine if their cost picture is out of line with other area hospitals. One hospital controller indicated that it would be particularly useful to be able to compare the salaries and costs of departments such as pharmacy with neighboring hospitals. Since the first reports were just completed in 1975, many hospitals have not yet been able to avail themselves of the opportunity. However, the Washington Commission reports that a number of hospitals have already commented on the internal management value of the information provided from the new system.

Uniform systems can also provide additional information for the department head's use in managing his department. Within the hospital industry, there is a division of opinion over what items should be related back to the cost centers for internal management purposes. Some maintain that the department head should not be burdened with considerations such as fringe benefits and overhead because there is nothing he can do to control these costs. This attitude favors continuation of the responsibility reporting system in which fringe benefits and overhead are kept in separate categories and not allocated to departments. Others feel that even though the department head cannot control the indirect costs, he still should be aware of both the direct and indirect costs of his department, in order to see its true operating costs. For this school of thought functional reporting becomes a useful tool for displaying total costs for the department head instead of just a burden imposed by an outside agency.

Some speculate that it is merely a lack of understanding within

the hospital of the range of information available from uniform accounting and reporting systems that limits the number of requests by department heads for data. It is felt that the individual department head will soon realize that he now has more information available to assist him in managing his own department and will begin to identify these new types of information and statistics during the preparation of the reporting package documentation. As an example, the use of relative value units in the laboratory are a much more meaningful way of allowing a pathologist or the laboratory director to assess the performance of his unit internally and in comparison to other hospitals. Therefore, it is likely that when the relative value unit system is in full operation, the pathologist or laboratory director will find the new system advantageous and will cease to complain about transferring from counts of the number of procedures to the new reporting mechanism.

Finally, it is maintained that the California and Washington manuals serve as excellent general accounting textbooks for hospitals. For instance, if one wonders how to allocate board meeting expenses, the accounting manual gives both a rationale and a specific method for doing it. Central Services and Pharmacy have always been problem areas in terms of defining items that should go under those services; now the manual spells out the requirements. The manual also includes guidelines on the capitalization of fixed assets, supplying many hospitals with their first formal policy on capitalization levels. Of course, it can also be argued that the textbook nature of the manual and its policy determination aspects take away hospital management prerogatives and severely limit the hospital's ability to determine its own policies. However, the proponents of the California and Washington systems point out that in many cases, the manual is more liberal in its philosophy than the management of many hospitals. For example, the California manual permits all capital expenditures of over $100 with a period of use of at least one year to be capitalized, although existing policy in many hospitals may require a greater value on the item, a longer period of use, or both.

SECTION V: UNITS OF MEASURE AND PROBLEM ACCOUNTS

From the perspective of both the designers and users of the California and Washington uniform accounting and reporting systems, the major deficiencies of the new systems lie in the statistical measures and the lack of relative value measurements for many aspects of patient care. It was agreed that most units of measure employed to measure hospital output and costs fail to assess complexity of work and are still too crude to serve as useful bases for performance indicators for internal or external monitoring of efficiency. The adoption of relative value scales for radiology and laboratory activities in Washington and California represent one important measure of progress, but these scales need considerable refinement. All agreed that the use of the "patient day" as the primary statistic for measuring hospital output must be replaced with more meaningful measures of patient use of hospital resources. Specifically, patient service units need to be developed by hospital departments that can be related to staffing patterns and services to show real differences in efficiency.

The purpose of the standard unit of measure is to provide a common statistic for measuring costs for all hospitals. The standard unit of measure for revenue-producing cost centers attempts to measure the volume of services rendered to patients, while the standard unit of measure for non-revenue-producing cost centers attempts to measure the volume support services rendered to the revenue-producing patient care departments. Distinct from the standard units of measure are the statistics that are used to allocate the costs of non-revenue-producing cost centers to each other and to the revenue-producing centers. For example, the unit of measure or output statistic for the admitting cost center in California is the number of admissions, while the cost-finding statistic is gross patient revenue. In some cases, the same statistical basis is used for both purposes.

In California, many public hearings were held for the purpose of reviewing and receiving comments and suggestions on the uniform accounting and reporting system. Very few suggestions on the details of the system or its statistics were offered. One hospital representative interviewed cited the statistics as the weakest aspect of the system, but cast the blame for poor statistics, not on the Commission, but on the hospital industry as a whole. The Washington Hospital Commission tried for six months to get suggestions for better units of measure, but completely without success. However, after the system was adopted, the Commission received volumes of suggestions - most of them contradictory.

In discussions with the hospital associations, selected hospitals, and the Washington and California Hospital Commissions, several problems with the statistics used for performance reporting and cost finding were cited. Some of the problems stem from new types of statistics employed by the two commissions, while others stem from statistics that are deemed inadequate measures of hospital activity. The following discussion illustrates some of the common problem areas in performance and allocation statistics as well as general accounting and reporting problems.

Central Services and Supplies

The account designated as Central Services and Supplies was cited by the hospital association representatives and the hospital financial managers interviewed as one of the most difficult areas in the shift from responsibility to functional accounting. Both the California and Washington accounting manuals require the hospital to charge all supply items to the central services account regardless of where these items are used in the hospital. In practice, many hospitals post that charge as revenue to the unit that uses the central services item. This provides an indication of the revenue-producing capability of units such as the emergency room or operating room. Under the Commission regulations, the cost of the supplies

stays in central services, and the revenue produced from patient charges for the supply go to central services, with no credit to the using unit.

As an example, let us assume that a pacemaker cost $1,200 and is installed by Hospital X at a charge of $1,500 to the patient. Under the traditional responsibility accounting system, the hospital would charge the expense of $1,200 and post the income of $1,500 to the operating room, resulting in a $300 profit for the operating room. Under the functional accounting system, the expense of $1,200 and the income of $1,500 for the pacemaker are posted to central services, and thus central services, not the operating room, is given credit for the $300 profit. The hospital claims that the functional system is misleading because by crediting supply profits to central services, it seems as if the operating room needs a higher hourly rate to break even. Therefore, the hospital needs to maintain the responsibility accounting system for internal purposes and to develop a functional accounting central service account for external reviewers. Hospital X can accommodate both needs by setting up separate subaccounts in the operating room account to record the expense for pacemakers and revenue from pacemakers. For functional accounting purposes, these subaccounts can be removed from the operating room and computed into central services.

In sum, the creation of a central services account is not an insurmountable obstacle for the hospitals, but it is an inconvenience that requires hospitals to maintain two sets of reports. The internal reports are set up by the traditional departments with patient chargeable supplies assigned to the using unit. These internal reports are then reworked through reclassifications to manually generate the external reports for the Commissions. If the hospital is computerized, the revenue and cost subaccounts for items charged to patients in service centers where dispensed are coded to enable reclassification to central services.

Pharmacy

In Washington, some difficulties in reporting the activities of the pharmacy were cited. Hospitals on a unit-dose pharmacy system or very small hospitals had problems complying with the manual requirement that line items be used as the standard unit of measure for pharmacy services. In these cases, the Commission modified the manual to allow the hospital to use either patient days or line items for pharmacy reporting. Large hospitals are still required to use line items as the unit of service.

Another complication arose in the hospitals that put the cost and revenue for I.V. solutions into the central supply instead of pharmacy as required in the manual. As discussed in the preceding section, this problem can be resolved through the use of subaccounts. Similarly, problems arising from the posting of pharmacy items used in surgery to pharmacy instead of surgery (these items might not even pass through pharmacy) can be solved by subaccounts to give surgery proper credit under the responsibility system.

Laboratory

Many hospitals in both California and Washington have begun to measure laboratory services by workload measurement units in California and relative value units in Washington as a result of implementation of the uniform accounting system. Although the use of these new measures requires some adaptation in the laboratory's statistical collection processes, the concept was viewed favorably by the hospitals interviewed in both states.

One hospital fiscal manager in California indicated that the laboratory keeps its records according to the number of tests or procedures provided, and then converts them to workload measurement units at the end of the year to comply with the Commission requirements. In Washington, one hospital controller interviewed had received a waiver from the Commission to give them an extra year to convert from recording the number of tests to

a relative value scale of measurement.

Although most of those interviewed felt that the relative value scales for X-ray and laboratory that now exists are quite adequate for rate-setting purposes, one California respondent criticized the College of American Pathologists (CAP) workload scale because it is based on the technician's time, instead of the pathologist's time. However, the California Commission favors the CAP units because they more accurately reflect the hospital productivity rather than physician productivity.

Printing and Duplication Statistics

Printing and duplication service reporting was cited by hospital financial officers in both California and Washington as an area that required too much detail. In both states, the hospital is asked to account for the number of reams of paper used as the standard unit of measure. This is not a statistic the hospital has traditionally collected, and is a difficult one to begin to collect. In Washington, it was pointed out that issues such as "reams of paper" as a statistic should have been resolved before the accounting system was implemented, but instead they now have to go back and correct the problem areas. Meanwhile, the hospitals feel that they have been subjected to an unrealistic demand.

In California, the Commission manual requests that the photocopying for each department be pooled together into one printing and duplication account. For responsibility accounting purposes, some hospitals use secondary numbers (subaccounts) for printing and duplication in each department. The same secondary account number is used for the duplicating machine in every cost center. At the end of the year, these secondary accounts are pooled and reclassified to conform with Commission requirements.

Acute Care Categories

Both California and Washington require the hospitals to break down their acute care performance statistics into pediatric acute, medical acute, and surgical acute although medical and surgical services are one cost centers in the cost allocation process. In Washington, the small hospitals were unable to comply with this level of detail and received a waiver from the Commission that allows them to report one overall statistic for acute care.

In California, the small hospitals have not been granted a waiver on this issue and must provide detailed breakdown. One hospital representative said that many hospitals in the 50-bed size category did not operate separate pediatrics units. Therefore, to comply with Commission requirements, the Medical Records department would have to review the medical records at the end of the year to determine how many of the ICU or medical/surgical acute cases were pediatric. One observer felt that most small hospitals would not pull every chart, but would take an average pediatric-to-adult ratio and use the average to compute the Commission's statistics. As a result, he predicted that the small hospitals' resulting statistics would be highly unreliable.

"Patient Business" Statistics

The fiscal manager for one of the California hospitals pointed out an area in which the hospital's attempts to innovate conflict with the Commission's accounting and reporting requirements. The Commission breaks "patient business" into admitting (account #8530) and credit and collection (account #8550). However, this hospital has introduced a new method for patient claims processing which makes such breakdowns difficult. Under the new concept, a patient service representative is assigned to the patient at admission and follows that patient through discharge and bill collection. The patient service representative's time allocated to

admitting services versus collection services varies with the individual patient, making it difficult to estimate the percentage of service representative time allocated to each activity. As a result, compliance with the Commission's detailed breakdown is cumbersome and requires the use of estimates instead of actual figures.

Food Services

The food services area offers an example of the problems arising when small hospitals are asked to comply with detailed reporting requirements for large hospitals. The Commission manuals in California and Washington have three separate food services accounts - dietary, kitchen, and cafeteria. In most of the smaller hospitals, all three types of services are run as one unit by the same people using common supplies. In California, the kitchen account is used for common costs of the dietary, kitchen and cafeteria activities and then these common costs are eliminated by reclassifying them to the dietary and cafeteria cost centers based on a count of meals served. Many small hospitals will have to estimate the distribution of costs between these activities. As a result of the estimation process, the statistics reported may lack uniformity and perhaps even reliability. In Washington, the basic service hospitals have been permitted to collapse the three accounts into one account to alleviate the problem. Small hospitals that exceed the basic service hospital definition have to comply with the detailed requirements by using estimates as in California.

Operating Room

Many hospitals in both Washington and California traditionally used the number of procedures or operations as the statistic to measure operating room activity. The Commission manuals require the hospitals to use minutes. Although the hospitals indicated that the keeping and using of a new statistic necessitated department head education, none viewed the

introduction of minutes as an operating room measure as a difficult statistic to implement. Some hospitals said that minutes had been recorded previously, but just not used for reporting purposes, while others indicated that minutes were an entirely new statistic.

Nursing Orientation

In California, one of the hospital fiscal managers noted that many hospitals have set up a separate cost center for inservice education and orientation activities for nurses. Although a cost center is designated for inservice nursing education, the California Hospital Commission makes no allowance for nurse orientation activities in its manual. The question of where to allocate the costs of nurse orientation then arises. The orientation program might acquaint the nurse with the hospital in general, in order to enable that nurse to eventually work on any unit. If that is the case, is it then fair to allocate the entire cost of that nurse's orientation to the first unit for which she works? The individual interviewed argued that general orientation activities should be kept in a separate account and any specialized training, such as orientation to ICU or CCU, should be charged to the specific unit.

Gross Patient Revenue as a Measurement Statistic

Both the California and Washington manuals use gross patient revenue as the statistical basis for the allocation of indirect costs for departments such as Medical Records, social services, or computer services to the revenue producing centers. This is not a difficult statistic for the hospital to use, but those interviewed felt it was not an accurate statistic on which to base the allocation. For example, if gross patient revenue is used as the statistic for computer services, an increase in revenues resulting from an increase in hospital rates would expand the computer services budget yet the volume and cost of computer services would remain unchanged. Thus, while computer service costs are allocated in accordance with fluctua-

tions in gross patient revenues, the cost of computer services are not directly related to those fluctuations.

In California, the social services and medical records departments are allocated to the revenue-producing centers using gross patient revenue as the statistic. It has been suggested that "time spent" would be a more accurate allocation statistic and would also bring the Commission's statistical bases in line with those used by Medicare.

Respiratory Therapy as a Cost Center

In Washington, respiratory therapy is listed as a separate cost center in the manual. Traditionally, hospitals have regarded respiratory therapy as a component of pulmonary function cost center and did not keep separate statistics for respiratory therapy. To simplify matters for the hospitals, the Commission allowed the respiratory therapy to be included under pulmonary function for the first year. California also designates respiratory therapy services as a separate cost center, but calls the center "inhalation therapy".

Square Footage as the Statistical Basis for Cost Finding

Both the California and Washington manuals use square footage as the statistical measure when allocating the costs of some of the non-revenue-producing departments to the revenue-producing departments. In California, an example of the problems inherent in using square footage as an allocation statistic was given for the plant operations cost center. Plant operations costs are allocated on a straight square footage basis. Thus, although the laundry with a small square footage uses 10-20 percent of the steam from the boiler in the plant operations cost center, the nurses dormitory with larger square footage would be allocated a greater proportion of the plant operation costs. A statistic that weighs the square feet by service complexity (similar to RVU's in the laboratory) would be a more accurate allocation measure.

Housekeeping is another area in California where square footage is used as the basis for cost allocation to revenue-producing centers. The use of square footage is criticized because the time and staffing required to perform housekeeping duties for one square foot of operating room space far exceeds the time and staffing required for one square foot of pharmacy space. It was suggested by some in California that the Medicare statistical basis of "time spent" would be more equitable. However, in Washington, where "time spent" is used as the statistical basis for allocation of housekeeping service, there were complaints that the time spent statistic was still not an adequate basis for allocation decisions.

SECTION VI: ADVICE FOR FUTURE EFFORTS

The current federal and state level concern over escalating hospital costs has promoted the concept of prospective rate setting to the forefront of health policy discussions and legislative action. As an underpinning and essential component of the rate-setting process, uniform accounting and reporting of hospital costs is now required by several states and may soon be required on a national basis. Thus prior experiences in implementing these systems become especially significant. What advice can the veterans in Washington and California offer?

First, the transition to uniform accounting and reporting can be filled with problems and, undoubtably, inconvenience to the hospital, but the difficulties do not appear to be insurmountable. In general, all hospital charges can be reclassified manually or by computer to the responsibility centers where the charges occur, permitting the hospital to retain its responsibility reporting system while meeting functional reporting requirements. In Washington, where rate setting exists, many hospitals expressed the view that the new system provides them with the means to compare their performance to other hospitals as well as a means of insuring that the rates they are given by the Commission are based on good information that reflects their true financial requirements.

Second, cooperation between the state agency and provider organizations in the resolution of technical obstacles encountered in system design and implementation is essential.

Third, there is an urgent need to refine existing standard units of measure and develop new measures of hospital services. Participants in both California and Washington feel the statistics sections of their systems are the weakest component. This was not for want of trying. The Executive Director of the Washington Commission states that the largest part of development time was devoted to this question. The Washington Commission has a technical advisory committee working on an on-going

review of statistics and the California Hospital Association is actively working on the development of a relative value system of assessing the work performed in hospital departments to replace the "patient day" statistic. All participants urge that development of statistical measures become a priority effort at the national and local level for the hospital industry and its regulators.

Fourth, standard reporting mechanisms should be developed for all third party payers. Under the existing requirements, the hospitals in Washington and California must submit separate reporting forms to the Commission, Medicare, Medicaid, and Blue Cross. The various parties do not employ common definitions and statistics. To avoid duplication and unnecessary burdens on the hospital, reporting forms should be designed to meet the need of multiple users.

Fifth, in-depth orientation sessions are essential to the successful implementation of a uniform system. The participants stressed the need to carefully review the system and required forms with the hospitals in training workshops before the hospitals are asked to implement the system. It was urged that CPAs and others who provide consultative or computer services to the hospitals be included in the sessions. Continuing education credit for the workshops was suggested as an incentive that could be offered. Small workshops with advance distribution of training materials was also suggested. Consideration should be given to conducting separate sessions for small hospitals. Moreover, it was urged that the sessions be repeated after implementation for the benefit of new personnel and to allow discussion of problems encountered as the system is put into operation.

Sixth, many of the hospitals will need technical assistance during the implementation process. The state or other implementing agencies should be funded to provide such assistance.

Seventh, recognition should be given to the problems encountered by small hospitals in complying with the system's detailed reporting

requirements. Where necessary, special provisions should be developed to accommodate the small hospital.

Eighth, it should be recognized that the implementation of any new system invariably results in delays, mininterpretation of some policies and procedures, and potentially the submission of inaccurate or unreliable data. It is suggested that two or three years of data submission and review may be required before the data from the hospitals is of adequate quality. During the phase-in period, it is recommended that careful auditing be used as a means of checking to see that the hospital has followed the classification and reporting convention guidelines. Desk audit review to see that the numbers add up is not enough.

Nineth, the necessity for an adequate amount of lead time to reprogram the hospital's computer system should be recognized. For example, California has provided a three year option for the transition to the actual numbering system in recognition of the complexities of the computer changeover.

Tenth, the use of staggered fiscal years should be considered to distribute the implementation burden on CPA firms, computer companies, and the implementating agency over the course of the year. The benefit of using staggered fiscal years must, of course, be weighed against the loss of reporting in a common time frame for comparison purposes. Peer groups of hospitals should, in any event, use the same fiscal years.

Eleventh, the implementing agency must remain realistic in its demands on the hospitals. When new statistics are to be collected, the hospital should be given an appropriate period of time in which to acquaint the department heads with the new record keeping requirements. Moreover, new statistics should be based whenever possible on current hospital practice and not be totally extraneous such as the notorious "reams of paper" requirement in Washington and California. If necessary, requirements should be phased in with waivers granted in the first year to ease the transition process.

The Washington and California experiences indicate that the transition to a uniform accounting and reporting system can be accomplished in a reasonable manner. However, both systems are still very new and analysis of the data submitted to the commissions is just beginning. Before a nationwide system or set of systems is implemented, a thorough evaluation of Washington and California should be conducted. In such an evaluation, a comparison of the quality of the date received by the two commissions could provide valuable insights into the issue of whether uniform accounting and reporting should be implemented before or concurrent with prospective rate setting.